DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 99-025

2. STATE: Minnesota

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Sections 1905(b) & 1911(a); 42CFR 447.201(b)

7. FEDERAL BUDGET IMPACT:
a. FFY '00 $ 460
b. FFY '01 $ 920

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 4.19-B. pp 1-1c
Att. 4.19-B. pp 57-57d

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same
Att 4.19-B pp 1-1c
Att 4.19-B. pp 57-57b

10. SUBJECT OF AMENDMENT:
Rates: IHS/638 Facilities

GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Mary Kennedy

13. TYPED NAME:
Mary B. Kennedy

14. TITLE:
Medicaid Director

15. DATE SUBMITTED:
December 29, 1999

16. RETURN TO:
Stephanie Schwartz
Minnesota Dept. of Human Services
444 Lafayette Road North
St. Paul, MN 55155-3853

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
12/30/99

18. DATE APPROVED: 3/26/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
April 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:
Cheryl A. Harris

21. TYPED NAME:
Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Insurance Oversight

23. REMARKS:

RECEIVED
DEC 30 1999
DMIO/MPC

FORM HCFA-179 (07-92)

Instructions on Back

MINNESOTA

MEDICAL ASSISTANCE

Federal Budget Impact of Proposed State Plan Amendment TN 99-25

Attachment 4.19-B: Methods & Standards for Establishing Payment Rates: IHS/638 Facilities

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Pursuant to Minnesota Session Laws 1999, chapter 245, article 8, section 8 (amending Minnesota Statutes, section 256B.094, subdivision 6), effective April 1, 2000, State plan amendment TN 99-25 authorizes Indian Health Service facilities and 638 facilities (tribally owned facilities funded by Title I or III of the Indian Self-Determination and Education Assistance Act (P.L. 93-638)) to be paid for child welfare-targeted case management (CWTCM) Medicaid services using the current Indian Health Service encounter rate. See Attachment 4.19-B, page 1c.

To estimate the federal costs, the Department compiled Document A. The Department reviewed the total number of CWTCM payments for 12 months (Column A), the total cost of those payments (Column B), and the average payment made to Indian Health Service and 638 facility delivery area counties billing for CWTCM services (Column C). Using ethnicity data from MMIS, an approximate total of Native American and Alaska Native recipients was derived for each county (Column D). Column F shows the percentage of Medicaid recipients who are Native American and Alaska Natives from the total number of Medicaid recipients by county (Column E).

The estimated number of CWTCM payments for Native American and Alaska Native recipients (Column G) was derived by using the percentages in Column F and the total number of CWTCM payments (Column A). Column G was then used to estimate the total number of encounters, if on average, a total of one, two, or three face-to-face encounters occurs per month (Columns H-J). The figures in Columns H-J were then multiplied by the current encounter rate of $172 to arrive at the cost figures in Columns K-M. The totals in Column L (i.e., an average of two encounters/month), when adjusted for Federal Fiscal Year 2000 (April 1, 2000-September 30, 2000) and Federal Fiscal Year 2001 (October 1, 2000 through September 30, 2001) are as follows:

	(in thousands)	
	FFY '00*	FFY '01
State costs	$0	$0
Federal costs	**$460,000**	**$920,000**
TOTAL	$460,000	$920,000

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
Other Types of Care

The following is a description of the policy and methods used in establishing payment rates for each type of care and services included in the State plan.

Medical Assistance payment for Medicare crossover claims is equal to the Medicare co-insurance and deductible.

IHS/638 Facilities: Except for child welfare-targeted case management services, services provided by facilities of the Indian Health Service (which include, at the option of a tribe, facilities owned or operated by a tribe or tribal organization, and funded by Title I or III of the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended, operating as 638 facilities) are paid at the rates negotiated between the Indian Health Service and the Health Care Financing Administration and published by the Indian Health Service in the Federal Register. Child-welfare targeted case management services are paid in accordance with the methodology in item 19.b., child welfare-targeted case management services.

Outpatient services provided by facilities defined in state law as critical access hospitals (and certified as such by the Health Care Financing Administration) are paid on a cost-based payment system based on the cost-finding methods and allowable costs of Medicare.

Except in the case of critical access hospitals, for obstetric care the base rate is adjusted as follows:

- outpatient hospital obstetric care (as defined by the Department) technical component (provided by outpatient hospital facilities) receives a 10% increase over the base rate.

- all other obstetric care (as defined by the Department) receives a 26.5% increase over the base rate.

Pediatric care (as defined by the Department), except for the technical component provided by an outpatient hospital facility, receives a 15% increase over the base rate.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
Other Types of Care (continued)

Legislation governing maximum payment rates sets the calendar year at 1989, except that the calendar year for item 7, home health services, is set at 1982. Rates for services provided by community and public health clinics are increased by 20%, except for laboratory services.

Exceptions to the 50th percentile of the submitted charges occur in the following situations:

(1) There were less than 5 billings in the calendar year specified in legislation governing maximum payment rates;
(2) The service was not available in the calendar year specified in legislation governing maximum payment rates;
(3) The payment amount is the result of a provider appeal;
(4) The procedure code description has changed since the calendar year specified in the legislation governing maximum payment rates, therefore, the prevailing charge information reflects the same code but a different procedure description;
(5) The 50th percentile reflects a payment which is inequitable when compared with payment rates for procedures or services which are substantially similar or when compared with payment rates for procedure codes or different levels of complexity in the same or substantially similar category; or
(6) The procedure code is for an unlisted service.

In these instances, the following methodology is used to reconstruct a rate comparable to the 50th percentile of charges submitted in the calendar year specified in legislation governing maximum payment rates:

(1) Refer to information which exists for the first four billings in the calendar year specified in legislation governing maximum payment rates; and/or
(2) Refer to surrounding and/or comparable procedure codes; and/or
(3) Refer to the 50th percentile of years subsequent to the calendar year specified in legislation governing maximum payment rates; and "backdown" the amount by applying an appropriate CPI formula. The CPI formula is updated July 1 of each year to incorporate the current year's CPI; and/or
(4) Refer to relative value indexes; and/or
(5) Refer to payment information from other third parties, such as Medicare; and/or

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
Other Types of Care (continued)

(6) Refer to a previous rate and add the aggregate increase to the previous rate; and/or
(7) Refer to the submitted charge and "backdown" the charge by the CPI formula. The CPI formula is updated July 1 of each year to incorporate the current year's CPI.

If a procedure was authorized and approved prior to a reference file rate change, the approved authorized payment rate may be paid rather than the new reference file allowable.

HCPCS MODIFIERS

Medical Assistance pays more than the reference file allowable in the following areas:

20 microsurgery = 35% additional reimbursement.

22 unusual procedural services = additional reimbursement based on line description or claim attachment. This modifier specifies a ratio for twin delivery and VBAC delivery. All other services are priced according to the service rendered.

99 multiple modifier = may be an increase or a decrease to the reference file allowable depending on the modifiers represented within the 99.

In accordance with Minnesota Statutes, §256B.37, subdivision 5a:

No Medical Assistance payment will be made when either covered charges are paid in full by a third party payer or the provider has an agreement with a third party payer to accept payment for less than charges as payment in full.

Payment for patients that are simultaneously covered by Medical Assistance and a liable third party other than Medicare will be made as the lesser of the following:

(1) the patient liability according to the provider/third party payer (insurer) agreement;

(2) covered charges minus the third party payment amount; or

(3) the Medical Assistance rate minus the third party payment amount.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
Other Types of Care (continued)

IHS/638 FACILITIES:

An encounter for a 638 or IHS facility means a face-to-face encounter/visit between a recipient eligible for Medical Assistance and any health professional at or through an IHS or 638 service location for the provision of Title XIX covered services in or through an IHS or 638 facility within a 24-hour period ending at midnight. Encounters/visits with more than one health professional and multiple encounters/visits with the same professional, within the same service category, that take place in the same 24-hour period, constitute a single encounter/visit, except when the recipient after the first encounter/visit suffers an illness or injury requiring additional diagnosis or treatment. Service categories for IHS/638 facilities are: ambulance, chemical dependency, dental, home health, medical, mental health, and pharmacy.

Services included in the outpatient rate include:

- outpatient hospital ambulatory surgical services
- outpatient physician services
- outpatient dental services
- pharmacy services
- home health agency/visiting nurse services
- outpatient chemical dependency services
- transportation services if the recipient is not admitted to an inpatient hospital within 24 hours of the ambulance trip

Services included in the inpatient rate include:

- inpatient hospital services
- transportation services if the recipient is admitted to an inpatient hospital within 24 hours of the ambulance trip

Inpatient physician services are paid in accordance with the methodology described in item ~~6.d.C., Ambulatory surgical centers~~ 5.a., Physicians' services.

The ambulatory surgical center facility fee is paid in accordance with the methodology for the technical component of the surgical procedure described in item ~~5.a., Physicians' services~~ 6.d.C., Ambulatory surgical centers.

19.b. **Child welfare-targeted case management services** as defined in, and to the group specified in, **Supplement 1a** to Attachments 3.1-A/B (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

The monthly rate is based on an aggregate of time spent performing all elements of case management services.

Payment is based on:

a. A face-to-face contact at least once per month between the case manager and the recipient or the recipient's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan in regard to the status of the recipient, the individual service plan, or goals for the recipient.

b. A telephone contact, for Minnesota recipients placed outside the county of financial responsibility in an excluded time facility under Minnesota Statutes, section 256G.02, subdivision 6, or through the Interstate Compact on the Placement of Children, Minnesota Statutes, section ~~257.40~~ 260.851, and the placement in either case is more than 60 miles beyond the county boundaries. The telephone contact must be between the case manager and the recipient or the recipient's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan in regard to the status of the recipient, the individual service plan, or goals for the recipient. There must be at least one contact per month and not more than two consecutive months without a face-to-face contact as described in item a., above.

Rate Methodology for IHS or Tribal 638 Providers:

Payment is $178 per encounter. This amount is the average of the monthly rate in the counties' Contract Health Service Delivery Area of federally-recognized reservations divided by two encounters per month. The rate will be recalculated annually.

19.b. **Child welfare-targeted case management services** as defined in, and to the group specified in, **Supplement 1a** to Attachments 3.1-A/B (in accordance with section 1905(a)(19) or section 1915(g) of the Act. (continued)

An encounter is defined as a face-to-face contact or a telephone contact occurring within a 24-hour period ending at midnight, as follows:

a. A face-to-face contact between the case manager and the recipient or recipient's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan in regard to the status of the recipient, the individual service plan, or goals for the recipient.

b. A telephone contact between the case manager and the recipient or recipient's family, primary caregiver legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan in regard to the status of the recipient, the individual service plan, or goals for the recipient.

This applies to a recipient placed outside the county of financial responsibility or to a recipient served by tribal social services placed outside the reservation, in an excluded time facility under Minnesota Statutes, section 256G.02, subdivision 6, or through the Interstate Compact on the Placement of Children under Minnesota Statutes, section 260.851. The placement must be more than 60 miles beyond the county or reservation boundaries.

To be eligible for payment, there must be at least one contact per month and not more than two consecutive months without a face-to-face contact.

Only one contact within a 24-hour period will be paid, except that encounters with more than one case manager in the same 24-hour period are payable if one case manager from a tribe and one case manager from the county of financial responsibility or a tribal-contracted vendor determine that dual case management is medically necessary and documentation of the need and the distinctive services provided by each case manager is maintained in the individual service plan.

19.b. **Child welfare-targeted case management services** as defined in, and to the group specified in, **Supplement 1a** to Attachments 3.1-A/B (in accordance with section 1905(a)(19) or section 1915(g) of the Act. (continued)

Rate Methodology for Entities Under Contract with a County or Tribal Social Services

The monthly rate for child welfare-targeted case management services provided by entities under contract with a county or tribal social services is based on the monthly rate negotiated by the county or tribal social services. The negotiated rate must not exceed the rate charged by the entity for the same service to other payers.

a. If the service is provided by a team of contracted vendors, the county or tribal social services may negotiate a team rate with a vendor who is a member of the team. The team must determine how to distribute the rate among its members.

b. If the service is provided by a team that includes contracted vendors and county or tribal social services staff, the costs for county or tribal social services staff participation in the team must be included in the rate for county or tribal social services-provided services. In this case, the contracted vendor and the county or tribal social services may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must document, in the recipient's file, the need for team child-welfare targeted case management and a description of the roles of the team members.

Rate Methodology for County Staff:

A statistically valid random moment time study, Minnesota's Social Service Time Study (SSTS), is used to construct a monthly rate for child welfare-targeted case management. The SSTS separates a case manager's time into a number of categories which constitute allowable case management activities and other, unallowable activities. The proportion of allowable to total activities, when multiplied by the over-all provider costs establishes the costs of case management activity.

19.b. **Child welfare-targeted case management services** as defined in, and to the group specified in, **Supplement 1a** to Attachments 3.1-A/B (in accordance with section 1905(a)(19) or section 1915(g) of the Act. (continued)

The percentage of time spent by service staff on allowable child welfare-targeted case management services is applied to quarterly costs of providing social services, and divided by three to arrive at the eligible cost per month. This figure is divided by the average number of clients who received case management services per month. The result is the rate used for child welfare-targeted case management. This process is repeated so that valid rates can be established for each class of providers. The SSTS will be valid at each class.

The rate represents one month's worth of eligible child welfare-targeted case management activity and only one claim is allowed per calendar month. The rate is the same for MA-eligible and non-MA-eligible children. In the payment process, *all* of the following conditions must be met in order for a claim to be made:

A. the child is a MA recipient;
B. the child received child welfare-targeted case management services that month; and
C. all documentation requirements are met.

The rate will be reviewed and updated annually, using the most current, available data.

Rate Formula:

CP = Average Quarterly Social Service Cost Pool for the most recent year for that class of providers

P = Percentage of eligible targeted case management time as identified on the most recent year of the SSTS for that class of providers

N = Monthly Average number of children receiving case management services for that class of providers using the most recent year's worth of data

(CP/3 x P) = Monthly costs of providing child welfare-targeted case management (TCM) for that class of providers

TCM/N = CW-TCM monthly rate for that class of providers

19.b. **Child welfare-targeted case management services** as defined in, and to the group specified in, **Supplement 1a** to Attachments 3.1-A/B (in accordance with section 1905(a)(19) or section 1915(g) of the Act. (continued)

~~Pursuant to page 1 of this Attachment, IHS/638 facilities providing child welfare-targeted case management services are paid at the rates published by the Indian Health Service in the Federal Register.~~